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TASK FORCE ON
ALTERNATIVE HEALTH CARE SERVICES
AMBULATORY CARE SUBCOMMITTEE

June 12, 1991

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July 9, 1991

Dear Colleague:

The Alternative Health Services Task Force has completed an Interim Report entitled Ambulatory Care. This Interim Report was formally received by the Health Advisory Network Steering Committee.

Consistent with the Minister of Health's desire to ensure adequate consultation, the Steering Committee invites input from those affected by the recommendations of the Task Force before it formalizes its own recommendations. A copy of the Interim Report of the Task Force is enclosed for your review and response. Copies have been distributed to individuals and organizations for comment. Other interested individuals may request a copy of the Interim Report from this office.

The sequence of the consultation process is outlined below:

1) The Interim Report of the Task Force was received by the Steering Committee.

2) The Steering Committee distributes the Interim Report to interested parties in the community for comment.

3) The community responses are to be forwarded to the Task Force for review in September, 1991.

4) The Task Force will submit its final Report to the Steering Committee, taking into account the reactions to the Interim Report.

5) The Steering Committee will review the final report of the Task Force to formulate options and recommendations for consideration by the Minister of Health.

Your written response to the Interim Report of the Task Force should be received on or before September 20, 1991.

Please send **TWENTY (20)** copies of your comments to:

Health Advisory Network
308 - 294 Portage Avenue
Winnipeg, Manitoba
R3C 0B9

Yours truly,

Brian Postmundson for

John G. Wade, M.D.
A/Chair
Health Advisory Network Steering
Committee

/ls
Enc.

HAN.PROMO-L

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EXECUTIVE SUMMARY

Ambulatory care is the mode of health service delivery in which patients arrive at the health service site, receive care, and leave on the same day. Inpatient care is care where the patient is admitted to a hospital and stays overnight.

Alternatives to inpatient care are likely to improve the quality, appropriateness, and effectiveness of health care, while reducing cost. The ambulatory care sector represents the most important sector in the health care system in terms of ability to provide cost-effective services that substitute for inpatient care.

Currently, there is no formal arrangement in Manitoba for the planning and management of either the health care system or the ambulatory care system. This issue must be addressed in order to promote increased reliance on alternatives to inpatient care. Only when this occurs can important strategies be developed to shift hospital services from an inpatient to an outpatient basis and to promote the evolution of an effective ambulatory care system.

A provincial strategic plan should be developed which specifically addresses inpatient care, ambulatory care, appropriate use of services, and physician resources. Research should be conducted into changing patterns of service use, physician payment mechanisms, and optimum models for the delivery of ambulatory care.

An ambulatory care strategic plan should be developed. It must ensure that patients receive cost-effective services and must improve the availability and accessibility of services in non-urban areas. To facilitate this, consideration must be given to which models of ambulatory care provision most appropriately meet these objectives. An optimum mix of these models must be developed. In addition, such a plan must introduce mechanisms to control increases in volume unrelated to effectiveness or population need. An ambulatory care strategic plan should be an integral part of a larger strategic plan for the health care system, and thereby be linked to changes in the hospital sector. Information needs are understood to be critical to the planning and evaluation process.

INTRODUCTION

The sub-committee was of the strong opinion that alternatives to in-patient care are likely to improve the effectiveness, appropriateness, and quality of health care, as well as reduce cost. In considering alternatives, the committee identified the importance of an improved and responsive ambulatory care system to provide alternative health care services. This sector clearly represents the most likely one in the health care system to provide a cost-effective substitute for inpatient care. The committee chose to focus on ambulatory care, while recognizing that primary health care and community care are also issues that deserve further consideration in planning to shift from a reliance on inpatient services. The latter two issues, therefore, have not been dealt with specifically in the report.

"Ambulatory care" in its broadest sense, can be described as the mode of health service delivery in which people ambulate to the health service site and, after receiving care, leave on the same day. Therefore, it excludes inpatient care (where the patient spends a full 24 hours at the health service location) and care in the home (where the health services are taken to the patient's place of residence).

Ambulatory care can, and should be, coordinated with other modalities of health service in order to ensure that care is comprehensive and coordinated. Coordination may be

with inpatient services, care provided in the home, public health services, rehabilitation services, and others. As such, ambulatory care represents one component of a continuum of health service.

Ambulatory care comprises a broad range of services and plays an important role in any health care system. The largest component of ambulatory care focuses on the delivery of primary care--the level at which the vast majority of medical services are delivered. The most important component of the ambulatory care sector, therefore, is dedicated to the provision of basic medical services.

Outpatient hospital services are ambulatory care services provided to people who are not admitted as "inpatients". Hospital-based home care departments are an exception to this because they coordinate care in the home. These departments and their services are not considered ambulatory care.

Day surgery, not-for-admission surgery, and outpatient surgery are synonyms for ambulatory surgery programs provided in hospital settings. Ambulatory surgical procedures may also be provided in free standing, independent centres.

In Manitoba, ambulatory care is currently delivered in the following types of settings:

- hospital based outpatient services,
- hospital affiliated free standing clinics and centres,

- independent free standing clinics and centres, and
- doctors' offices

A complete listing of possible types of services in each of these settings is outlined in Appendix A.

THE NEED FOR PLANNING, MANAGING, AND DIRECTING

One of the main aims of the Canadian Medicare Program was to eliminate price as a barrier to the receipt of necessary health services. Laudable as that goal may be, it has four undesirable side effects:

- it eliminates the price mechanism as a tool for determining allocation of health resources,
- it eliminates price competition among providers,
- it eliminates consumer awareness, and
- it invites over-servicing by the fee-for-service system which rewards the provision of more and more services, regardless of their benefits.

Canadian Medicare has certain intrinsic characteristics that have enabled Canadians to control costs to a much greater extent than has been possible in the American system, despite these four weaknesses.[1]

Centralized public administration has substantially lowered the share of the health care dollar being spent on

the administrative "overhead" costs of the system. Monopoly control over funding has restrained the growth in expenditure mostly through the control over provider fee schedule increases and hospital expenditures.[2] Relatedly, it has lessened the duplication of expensive high technology services and the proliferation of such services, relative to what has occurred in the American system.[3]

Although Canadian Medicare has provided universal coverage at a far lower per capita cost than an American system (which leaves an estimated 39 million persons uninsured and many others underinsured)[4], there is a pervasive perception that the Canadian system costs too much, and that costs are rising at a rate which is beyond the fiscal capacity of the country. Furthermore, increasingly there is a perception that resources are being misallocated, with too little emphasis on prevention, an over reliance on inpatient service delivery, and increasing dependence on technologies and interventions which remain unproven in terms of their effectiveness.

In the absence of the market mechanism, as numerous provincial task forces across Canada in recent years have concluded, the time has come for provincial health plans to switch from their roles of insurers of health services to an upgraded role of providing leadership, planning expertise, direction, evaluation, and overall management of the system as a whole. A well-managed approach can address some of the weaknesses resulting from the lack of an effective market.

It can also introduce mechanisms to facilitate sound health outcomes and promote efficiency and effectiveness of the system.

Section 22 of the Manitoba Health Services Insurance Act entitled "Powers of the Commission" states:

> Without restricting the generality of Section 21, but subject as otherwise expressly provided in this or any other Act of the Legislature, it is the function of the commission and it has power
>
> a) to provide insurance for residents of Manitoba in respect of the costs of hospital services, medical services, and other health services; and
>
> b) subject to the approval of the Minister , to plan, organize, and develop throughout the province, a balanced and integrated system of hospitals and related facilities and services commensurate with the <u>needs of the residents of the Province.</u>[emphasis ours]

Clearly, the Commission has fulfilled its mandate under (a); however, it has hitherto not endeavored in a formal way to exercise its authority under clause (b). Instead, the Commission has essentially acted as a passive facilitator or a crisis manager. The system has developed, through the provision of funding, to underwrite the plans of the various individual providers.

The Subcommittee on Ambulatory Care determined, from interviews with staff of the Manitoba Health Services Commission, that the Commission does very little planning. Furthermore, it appears that the Commission does not have the staff capacity and expertise to carry out planning functions. The role in the allocation of resources is generally confined to recommending the choices between

competing provider demands for r[illegible]rces to the Minister, negotiating with providers, and [illegible]e policing of the system.

Thus, the responsibility for the overall planning of Manitoba health services has not been formally assigned to either the Commission or the Department of Health. The capacity does not exist for strategic planning to occur.

In the absence of a planning capacity, the Commission also lacks a strategic plan for ambulatory care and health care delivery in general.

Therefore, the committee recommends the development of a strategic provincial plan in order to facilitate optimum and rational development of health care in the Province of Manitoba.

Following the development of a provincial plan:

The committee recommends that a capacity must be created within the provincial system which can implement, evaluate, and modify the plan accordingly. A Provincial plan must be managed in a coordinated and rational manner, and therefore, expertise in these necessary areas must be sought.

OTHER ISSUES

In addition to the lack of planning, oth[illegible] main issues in ambulatory care are the following:

- the extent to which cost savings or more appropriate uses of resources could be achieved by shifting hospital services from an inpatient to an outpatient basis. This would necessitate a reduction in hospital capacity through the closure of beds, or change in their use, in order for savings to be realized.

- how to control the increases in the volume of services provided in ambulatory care in a manner consistent with medical need

- what are the optimum models or blends for the delivery of ambulatory care

- how to adequately service low population density areas in rural and northern Manitoba

- how to adequately and efficiently service high risk populations.

- the extent to which education of consumers and professionals can influence patterns of care

The achievability of cost savings for the health care system through treating a person on an outpatient rather than on an inpatient basis, should generally be obvious. For example, in comparing surgery performed on an inpatient versus an outpatient basis, one would expect the costs associated with the procedure itself (surgical suite,

medical and surgical supplies, drugs and gases, recovery room costs etc.) to be identical. The major cost differences occur in the pre-operative and post-operative period. For outpatient surgery the savings to the health care system would be the "hotel costs" of an inpatient stay, associated nursing costs, and any other costs of the stay, minus the costs of any ambulatory care or services delivered in the home that the patient would not have received if the procedure had been performed on an inpatient basis.

The Victoria General Hospital conducted a two year demonstration project to assess the impact of providing ambulatory surgery as an alternative strategy for delivering health care to patients traditionally treated in hospital. The study findings revealed that the costs to the Victoria Hospital for ambulatory surgery patients are less than those for in-patients.[5]

One determinant of whether the shift in emphasis to outpatient care results in cost savings for the system is the amount of outpatient capacity created, and the resulting increase in the volume of outpatient services. If the provision of ambulatory surgery results in the performance of a greater number of procedures, such a shift may actually increase costs, even if hospital beds are closed. Whether the savings in costs at the patient level are translated into net savings for the health care system also depends on whether inpatient resources are freed up. If beds freed by the shifting of services to an outpatient basis are closed,

then the system will achieve net savings. If excess demands for beds exist, and the freed beds are used for rendering appropriate inpatient services, then the outpatient substitution would increase costs, but a more efficient utilization of resources would be achieved. In either event, the outpatient substitution is a desirable end because the objective of a government sponsored health program is to provide all medically necessary services at the lowest cost consistent with quality care; it is not to save money by failing to provide medically necessary services.

The cross-sectional evidence that rates of hospitalization can be decreased is of three main types. First, the American Health Management Organization experience shows that hospitalization rates are 25-45% lower for salaried physician HMOs than for conventional fee-for-service practices.[6] Additionally, reviews of admissions in the United States for fee-for-service practices, have shown that inappropriate utilization ranges from 6 to 40% of admissions and 12 to 39% of days of care.[7,8] To some extent, this may stem from the excess capacity of the American system; the same quantitative reduction in hospitalization rates may not be achievable in Canada. However, Health Management Records Institute data shows differences of as much as 28% in the outpatient orientation of provincial hospital systems, and even wider differences between individual hospitals.[9] Small area utilization

studies in Manitoba and the United States also suggest that there are wide geographic variations in hospitalization rates and surgical procedures per capita that are basically unexplainable. Morbidity patterns do not clearly explain these differences..[10, 11, 12, 13]

The corroborative trend analyses show that the advent of prospective payment systems for inpatient services in the United States has resulted in a dramatic decrease in inpatient activities and a continued growth in outpatient activities, which were not subject to the same prospective payment controls.[14, 15] Some of this change in conventional wisdom as to what procedures require hospitalization has also spread to Canada. The experience of both countries shows that the closure of beds in a hospital leads not only to a reduction in the length of stay, but also a shifting towards outpatient care.

Since the criteria for the determination of when hospitalization is required are obviously elastic, one can conclude that there may be more scope for creative outpatient substitution, especially in jurisdictions and hospitals which provide proportionally fewer outpatient services than their counterparts. Given the lack of definitive information available in Manitoba:

The committee recommends that issues related to hospital resources utilization patterns (inter- and

intra-provincially, and nationally) be referred to the Ministry as requiring further study.

The small area analyses of fee-for-service services suggest that there is considerable elasticity in the determination of when the services are medically necessary. This is reinforced by the difficulty that the American Medical Association/Rand Corporation project and other similar ventures have had in facilitating groups of physicians to achieve consensus in protocols or criteria for when services are necessary. At the present time, the Ontario College of Physicians and Surgeons and the Ontario Medical Association are developing treatment protocols and criteria for determining when services should be provided.

The committee recommends that consensus protocols be developed and adopted in Manitoba; and criteria be established for determining when services are medically necessary. Priority should be given to surgery and diagnostic services.

Studies of the cross-sectional relationships between the supply of practitioners in one area and the levels of servicing, and time series relationships between the supply of physicians and the volume of services provided, have also supported the conclusion that there is some degree of over-servicing in the system.[16] These studies show that the per

capita utilization is a function of the supply of physicians.

> The committee recommends that Manitoba Health examine the relationship between the supply of physicians and the level and volume of services, develop the capacity to regularly monitor manpower needs, and take appropriate steps to influence distribution and supply of physicians.

The final observation is that in Manitoba and elsewhere, the growth of services in the semi-controlled hospital sector, whose capacity to render services hitherto has been largely (but not completely) related to its bed supply, has been far exceeded by the growth in the less controlled ambulatory care setting.

> The committee recommends that Manitoba Health study other ways of controlling the growing volume of ambulatory care services.

The argument for new models of providing ambulatory services, with less emphasis on the fee-for-service model, usually focus on the need for a shift to salaried practice to eliminate incentives for physicians to over-service and perform procedures at the expense of the less remunerative prevention of disease.[17]

The committee recommends that Manitoba Health study the comparative efficacy and cost savings of salary vis-a-vis fee-for service reimbursement mechanisms for physicians.

The committee further recommends that Manitoba Health study the efficacy and relative cost of various practice settings. (i.e. private practice, community health centres, walk-in clinics, etc.)

The committee recognizes that most health care practitioners are trained in inpatient settings. This does not provide them with appropriate skills for ambulatory care.

The committee recommends that an increased emphasis be placed on training in the ambulatory care setting for all health care professionals.

The Rural Task Force dealt with the improvement of servicing of low density, non-urban areas, therefore, there is no need to elaborate on this subject here except to say that the issue must be addressed in the strategic plan for ambulatory care.

OBJECTIVES OF AMBULATORY CARE STRATEGIC PLAN

The ideal model for ambulatory care must be founded on clearly defined objectives. The committee recommends that

the following are critical elements of an ambulatory strategic plan. As such, the committee has elected to repeat these objectives as separate recommendations.

1. Ensure that patients receive treatment from the most cost-effective modality possible, while maintaining or improving the quality of care. Inpatient services should be replaced, to the extent possible by outpatient or community based services. Similarly, ambulatory care should be delivered in the community rather than in the hospital setting.

2. Develop an optimum mix of models for the delivery of ambulatory care from the standpoints of the quality of patient care, low unit cost, and control over total cost subject to the requirement to provide all medically necessary services.

3. Strengthen the controls to minimize the rendering of unnecessary fee-for-service services.

4. Facilitate the shifting to outpatient service, while also guarding against the proliferation of these services as a way for physicians to adapt to the constraints on income imposed by a fixed or reduced supply of hospital bed

5. Improve the availabilit, and accessibility of services in non-urban areas of the province.

6. Coordinate the shift in hospitals' emphasis on outpatient servicing to avoid duplication and gaps. A master plan for the various hospitals in the system would be required.

7. Ensure effective support to patients in the community is in place to enhance the continuity of care.

8. Identify changes in information systems required for planning, managing, and evaluating the ambulatory care sector. For example:

   a) Inter-provincial comparative data, such as that produced by the Health Management Records Institute, to monitor the comparative performance of the province and individual hospitals in the shifting of services to an outpatient basis.

   b) Better classification systems for capturing and analyzing trends in the utilization of ambulatory services.

   c) The coding of outpatient visits.

   d) A comprehensive workload measurement system required for outpatient activities.

   e) Training of hospital personnel and auditing of their information required for inter-hospital consistency.

f) Identify outpatient procedures to track substitutions.

g) Development of a standard plan of information requirements from all sectors of health care, including the institution based services and community based services.

h) Development of a regular utilization review of services from various service delivery sites.

9. Determine incentives, regulations, and/or controls and administrative structures necessary to achieve the aims of the overall plan.

10. Provide for more flexibility in the utilization of resources; and to foster innovation.

11. Ensure proper evaluation of programs under the strategic plan and the plan itself.

12. Study the impact of educating consumers on the costs and appropriate use of all health care services, including ambulatory care.

13. Include in the strategic plan, to the extent possible, measurable quantitative objectives derived from experience in progressive jurisdictions; eg. proportions of surgical procedures provided on an ambulatory basis.

14. Determine the changes necessary in the Manitoba Health Services Commission, Manitoba Health, and/or the Ministry in order to establish the capacity to plan, direct, lead, evaluate, and manage ambulatory care within the health care system in Manitoba.

CONCLUSION

The Province of Manitoba should appoint a high profile implementation committee, provide it with the necessary resources (including a support system), and funds to hire consultants and other expertise required to develop a provincial strategic plan for ambulatory care, and an action plan for implementation.

This implementation committee should include representatives from stakeholder organizations, but the majority should be comprised of independent health care experts and others from the community.

GENERAL RECOMMENDATIONS

1. The committee recommends the development of a strategic provincial plan in order to facilitate optimum and rational development of health care in the Province of Manitoba.

2. The committee recommends that a capacity must be created with the provincial system which can implement, evaluate, and modify the plan accordingly. A provincial plan must be managed in a coordinated and rational manner and therefore, expertise in these necessary areas must be sought.

3. The committee recommends that issues related to hospital resources utilization patterns; inter- and intra-provincially, and nationally, be referred to the Ministry as requiring further study.

4. The committee recommends that consensus protocols be developed and adopted in Manitoba; and criteria be established for determining when services are medically necessary. Priority should be given to surgery and diagnostic services.

5. The committee recommends that Manitoba Health examine the relationship between the supply of physicians and the level and volume of services, develop the capacity to regularly monitor manpower needs, and take

appropriate steps to influence distribution and supply of physicians.

6. The committee recommends that Manitoba Health study other ways of controlling the growing volume of ambulatory care services.

7. The committee recommends that Manitoba Health study the comparative efficacy and cost savings of salary and fee-for-service reimbursement mechanisms for physicians.

8. The committee recommends that Manitoba Health study the efficacy and relative cost of various practice settings. (i.e. private practice, community health centres, walk-in clinics, etc.)

9. The committee recommends that an increased emphasis be placed on training in the ambulatory care setting for all health care professionals.

AMBULATORY CARE STRATEGIC PLAN RECOMMENDATIONS

The following are critical elements of an ambulatory care strategic plan:

1. The committee recommends that an ambulatory care strategic plan must ensure that patients receive treatment from the most cost-effective modality possible, without jeopardizing the effectiveness and

quality of care. Th recommendation requires the substitution of inp ent services, to the extent possible, with outpatient or community based services; and ambulatory care be delivered in the community rather than in the hospital setting.

2. The committee recommends that an ambulatory care strategic plan must consider the development of an optimum mix of models for the delivery of primary care services from the standpoints of the effectiveness and quality of patient care, low unit cost, and control over total cost subject to the requirement to provide all medically necessary services.

3. The committee recommends that an ambulatory care strategic plan must strengthen the controls to minimize the rendering of unnecessary fee-for-service services.

4. The committee recommends that an ambulatory care strategic plan must consider the facilitation of shifting to outpatient services, while also guarding against the proliferation of these services by providers, as a way of adapting to the constraints on income imposed by a fixed supply of hospital beds.

5. The committee recommends that an ambulatory care strategic plan must improve the availability and

accessibility of services in non-urban areas of the province.

6. The committee recommends that an ambulatory care strategic plan must coordinate the shift in hospitals' emphasis on outpatient servicing to avoid duplication and gaps. A master plan for the various hospitals in the system would be required.

7. The committee recommends that an ambulatory care strategic plan must ensure effective community-based support is in place to enhance the continuity of care.

8. The committee recommends that an ambulatory care strategic plan must identify changes in information systems required for planning, managing, and evaluating the ambulatory care sector. Changes which require careful evaluation are:

   a) Inter-provincial comparative data, such as that produced by the Health Management Records Institute, to monitor the comparative performance of the province and individual hospitals in the shifting of services to an outpatient basis.

   b) Better classification systems for capturing and analyzing trends in the utilization of ambulatory services.

   c) The coding of outpatient visits.

d) A comprehensive workload measurement system required for outpatient activities.

e) Training of hospital personnel and auditing of their information/data to ensure required for inter-hospital consistency.

f) Development of a standard plan of information requirements from all sectors of health care, including the institution based services and community based services.

g) Development of a regular utilization review of services from various service delivery sites.

9. The committee recommends that an ambulatory care strategic plan must identify incentives, regulations, and/or controls and administrative structures necessary to achieve the aims of the overall plan.

10. The committee recommends that an ambulatory care strategic plan must provide for more flexibility in the utilization of resources; and to foster innovation.

11. The committee recommends that an ambulatory care strategic plan must ensure proper evaluation of programs under the strategic plan and the plan itself.

12. The committee recommends that an ambulatory care strategic plan must study the impact of educating

consumers on the costs and appropriate use of all health care services, including ambulatory care.

13. The committee recommends that an ambulatory care strategic plan, to the extent possible, must include measurable quantitative objectives derived from experience in progressive jurisdictions; eg. proportion of surgical procedures provided on an ambulatory basis.

14. The committee recommends that an ambulatory care strategic plan must determine the changes necessary in the Manitoba Health Services Commission, Manitoba Health, and/or the Ministry, in order to establish the capacity to plan, direct, lead, evaluate, and manage the health care system in Manitoba.

GLOSSARY OF TERMS

Ambulatory Care

- health service delivery in which people ambulate to the health service site and, after receiving care, leave the site on the same day.

Ambulatory Surgery

- surgery performed on patients who spend less than 24 hours on site. This includes both minor ambulatory surgery where care is provided to non-hospitalized patients, local anesthesia is used, and there is immediate discharge; and major ambulatory surgery, - where general , regional, or local anesthesia is used, and a period of post operative recovery or observation is utilized before the patient is discharged.

Inpatient

- the patient spends more than 24 hours at a hospital, and is admitted to the facility

Outpatient

- patient receives treatment/service at a hospital, but is not admitted to the facility

Home Care

- health services are taken to the patient's place of residence

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APPENDIX A

Examples of Types of Ambulatory Care

I. Hospital Based Outpatient Services

1. Emergency Visits

a) Emergent Patients - life or functional ability threatened without immediate medical intervention.

b) Urgent Patients - may progress to emergent stage if treatment is delayed up to 24 hours.

c) Non-Urgent - service could be provided in another setting
- service is not needed within a 24 hour time span
  i) unscheduled - patient initiated
  ii) scheduled - physician initiated

2. Outpatient Clinics - provide primary care, speciality care, and sub-speciality modes of ambulatory care, which may include diagnostic and/or therapeutic services. Clinics provide minor procedures requiring neither general anesthesia nor post operative observation (e.g. excision of warts, moles etc.; suture removal, cast removal); eye exams; pre- and post -operative visits; other diagnostic testings; and other medical treatments and examinations. Examples are:

- endoscopy clinics
- medical clinics
- obstetrical clinics
- paediatric clinics
- psychiatric clinics
- rehabilitation clinics

- surgical clinics

3. Diagnostic and Therapeutic Outpatient Services

a) Physician Based Services

Examples are:

- clinical laboratories
- diagnostic images
- electrodiagnosis
- other diagnostic
- radiation oncology
- respiratory therapy

b) Allied Health Professional Services

Examples are:

- audiology
- dialysis
- nursing
- occupational therapy
- physiotherapy
- prosthetics and orthotics
- psychology
- recreational therapy
- social work
- speech therapy

4. Day and Night Care Programs - units for patients to attend for a prescribed number of hours per day.

a) Day Surgery

i) Day Surgery - Category I - requires pre-admission work-up; general anesthesia, regional block or sedation; and post-operative observation in a recovery room or observation unit with dedicated nursing care. Examples are:

- amniocentesis
- breast biopsy and local excision for non-malignancy
- cardiac catheterization
- carpal tunnel release
- dilation and curettage
- hernia procedures

- laporoscopic tubal interruption
- lens procedures
- myringotomy
- some endoscopy
- surgical procedures
  (These are some examples of many. See Appendix B for a more detailed listing.)

ii) Day Surgery - Category II - requires hospital resources (Staff support, equipment, etc., not available in physicians' offices); local anesthesia or sedative (e.g. IV Valium and/or nursing support during treatment or procedure and post-procedural assessment. Examples are:

- chemotherapy
- intravenous therapy
- invasive diagnostic procedures
- plasmapheresis
- ultraviolet light therapy

b) Medical/Therapeutic Day or Night Care

Examples are:

- alcoholism day or night care
- diabetic day care
- dialysis day or night care
- drug addiction day or night care
- geriatric day hospitals
- psychiatric day or night care

5. District Health Centres

II. Hospital Affiliated Free Standing Clinics and Centres

1. <u>Family Practice Clinics</u>

Group practices offering community based health care services can be formally affiliated with hospitals. These affiliations have been established in order to link delivery of ambulatory and inpatient care through family physicians.

2. Community Health Centres

There is one community health centre in Manitoba with a formal affiliation with a hospital. The community health centre provides multidisciplinary primary health services, and is able to access secondary services via its hospital affiliation.

III. Independent (Non-Hospital Affiliated) Free Standing Clinics

1. Community Health Centres

These centres offer a blend of health and social services to specific populations. Services are provided through a multidisciplinary approach.

2. Physicians Practices (solo or group)

Private physician practice sites are located throughout Manitoba. Services may be primary care or specialty in their orientation.

3. "Walk-in" Clinics

Private medical clinics have been established by physicians which offer accessible medical services on a no appointment, extended hour basis. "Walk-in clinics do not commonly provide ongoing primary care medical services.

4. Surgical Centres

Examples are:

- cataract surgery centre
- plastic surgery centre

5. Public Health Clinics

Examples are:

- child health and parenting program
- diabetes education
- foot care clinics
- healthy weights, diet, and cancer
- immunization clinics and monitoring
- pre-natal classes
- well baby clinics
- workshops on healthy lifestyles
- workshops on management of sexually transmitted disease

Examples of Ambulatory Surgery Procedures

.able 2.1.
Procedures Performed in Surgicenter[a], Phoenix, Arizona[a]

ENT
- Adenoidectomy
- Antral puncture, Caldwell-Luc
- Arch bars, removal or application of
- Branchial cleft cystectomy
- Ethmoidectomy
- Laryngoscopy, with or without operative procedure
- Mastoidectomy
- Mouth biopsy
- Myringoplasty or tympanoplasty
- Myringotomy with or without tubes
- Nasal fracture, closed or open reduction of
- Nasal polypectomy
- Otoscopy, with or without removal of foreign body
- Palate biopsy
- Myringotomy tube removal
- Septal reconstruction, SMR, Septoplasty
- Tonsillectomy, with or without adenoidectomy
- Tongue biopsy
- Zygomatic fracture, closed or open reduction of

Eye
- Cataract excision
- Chalazion removal
- Conjunctiva, repair of
- Ectropion, repair
- Entropion, repair
- Enucleation
- Examination
- Lacrimal duct probing
- Eye muscle operation—recession or resection
- Lacrimal duct reconstruction
- Pterygium excision
- Dacryocystorhinostomy
- Tarsorrhaphy
- Foreign body removal

General Surgery
- Abscess, I & D
- Anal tag, excision
- Breast mass, excision or biopsy
- Bronchoscopy, with or without operative procedure
- Cervical node biopsy
- Cyst excision
- Epigastric hernioplasty
- Esophagoscopy, with or without operative procedure
- Excision hyperhidrotic glands, axillae
- Fistulectomy, fistulotomy
- Femoral hernioplasty
- Foreign body removal
- Frenulectomy, frenulotomy
- Hemangioma excision
- Hemorrhoidectomy
- Hydrocelectomy
- Inguinal hernioplasty, infant/adult
- Laceration repair
- Lipoma excision
- Mass excision
- Muscle biopsy
- Nail and/or matrix excision
- Orchidectomy
- Orchiopexy
- Pilonidal cystectomy
- Rectal biopsy, dilatation, polypectomy
- Sigmoidoscopy with or without operative procedure
- Skin lesion excision
- Stitch granuloma removal
- Subcutaneous mastectomy for gynecomastia
- Suture removal
- Thyroglossal duct cyst excision
- Torticollis repair
- Umbilical hernioplasty
- Umbilical sinus excision
- Varicose vein ligation, stripping
- Ventral hernioplasty
- Vermilionectomy

GYN
- Adhesions of clitoris, release of
- Bartholin cystectomy, marsupialization
- Cautery vaginal cyst
- Cervical conization
- Cervical dilatation
- Cervical polypectomy
- Colpotomy
- Colporrhaphy
- Colposcopy
- Condylomata acuminata, removal of or fulguration of
- Cryotherapy, with or without biopsy
- Culdocentesis
- Culdoscopy
- Dilatation and curettage
- Episiotomy
- Exam under anesthesia
- Hymenotomy, hymenectomy
- Hysterosalpingogram
- Hysteroscopy
- IUD removal
- Laparoscopy, with or without D&C
- Laparoscopy, bilateral tubal coagulation, transection or occlusion
- MacDonald's cerclage
- Mini-laparotomy for tubal ligation
- Perineoplasty
- Perineorrhaphy
- Rectovaginal fistula repair
- Transvaginal ligation of tubes
- Tubal insufflation
- Vaginal biopsy
- Vaginal stenosis release
- Vaginal tumor excision
- Vaginoplasty
- Vulvar biopsy

Table 2.1—*continued*

Neurosurgical
- Carpal tunnel decompression
- Intercostal neurectomy
- Morton s neuroma excision
- Neuroma
- Ulnar nerve transfer
- Resection temporal artery

Orthopaedic
- Anstospan injection
- Arthrodesis
- Arthroplasty
- Arthroscopy
- Arthroscopy with or without operative procedure
- Arthrotomy
- Baker s cyst excision
- Bone biopsy
- Bone graft
- Bone reconstruction
- Bunionectomy
- Bursectomy
- Carpal tunnel decompression
- Cast change with x-ray
- Closed reduction fracture
- Corn removal
- Exostectomy
- Fasciectomy
- Ganglionectomy
- Hammertoes, correction of
- Hardware removal
- Ligament repair
- Manipulation of joints
- Metatarsal head excision
- Morton s neuroma excision
- Neurolysis
- Nerve repair
- Neuroma removal
- Olecranon bursa excision
- Open reduction fracture
- Osteotomy
- Phalangectomy
- Plantar wart excision
- Reconstructive hand surgery
- Sequestrectomy
- Synovectomy
- Tendon repair, tenotomy
- Tenovaginotomy
- Tenosynovectomy
- Ulnar nerve transfer

Plastic Surgery
- Abdominoplasty/lipectomy
- Basal cell CA excision
- Blepharoplasty
- Brachioplasty
- Browlift
- Capsulotomy, breast
- Chemical peel
- Chin augmentation
- Dermabrasion
- Evacuation hematoma, breasts
- Evacuation hematoma, face
- Exchange of breast implants
- Flap revision
- Hair transplant
- Implant removal
- Lesion excision with graft
- Mammoplasty, augmentation
- Mammoplasty, reconstruction
- Mastopexy
- Otoplasty
- Reduction mammoplasty
- Rhinoplasty
- Rhytidectomy
- Scar revision
- Skin grafting
- Thigh lift

Urological
- Circumcision
- Cystoscopy
- Hydrocelectomy
- Lithotripsy
- Meatoplasty
- Meatotomy
- Orchiectomy
- Penneal needle biopsy
- Prostate biopsy
- Testicular biopsy
- Testicular prosthesis insertion
- Transurethral resection bladder tumor
- Urethral dilation
- Varicocele excision
- Vasectomy
- Vasovasotomy

Blocks
- Caudal
- Coeliac
- Intercostal
- Lumbar sympathetic
- Stellate
- X-ray with block

Dental Procedures
- Impacted wisdom teeth, removal of
- Multiple teeth extractions
- Operative dentistry
- Periodontal surgery

*With the permission of R. C. Williams, Executive Director, Surgicenter®, Phoenix, Arizona.

Table 2.2.
Procedures Performed in Ambulatory Surgical Center, Watts-Durham General Hospital, Durham, North Carolina*

ENT
- Adenoidectomy
- Adenoidectomy with BTT
- Antrostomy
- Bilateral tube myringotomy
- Bone Removal
- Bronchoscopy
- Esophagoscopy
- Exam under anesthesia
- Gum or mouth cysts
- Lymph node, excision
- Microlaryngoscopy
- Myringotomy tube removal
- Nasal polypectomy
- Nasal reconstruction
- Observation
- Otoplasty
- Reduction fracture, open or closed
- Septoplasty
- Tongue frenulotomy
- Tonsillectomy, with or without adenoidectomy
- Turbinectomy
- Tympanoplasty

Eye
- Blepharoplasty
- Capsulotomy
- Cataract
- Chalazion removal
- Crawford tube insertion
- Cyst removal
- Ectropion, repair
- Entropion, repair
- Examination
- Eye muscle procedure, recession or resection
- Foreign body removal
- Lacrimal duct probe
- Pterygium excision
- Reconstruction
- Recession lens
- Suture bleeder
- Suture removal

General Surgery
- Anal warts, excision
- Arteriogram
- Breast mass, excision or biopsy
- Bronchoscopy
- Cervical node biopsy
- Cyst removal
- Esophagoscopy
- Excision hydrocoelectis
- Fistulectomy
- Foreign body removal
- Hemorrhoidectomy
- Hickman's catheter insertion
- Inguinal hernia, infant or adult
- Incision and drainage, abscess
- Lipoma, excision
- Mass excision
- Muscle biopsy
- Nail excision
- Nevi excision
- Orchiopexy
- Pacemaker battery box replacement
- Phalangectomy
- Pilonidal cystectomy
- Proctoscopy
- Rectal polypectomy
- Skin lesion, excision
- Suture removal
- Tendon repair
- Umbilical herniorrhaphy
- Varicose vein ligation, stripping
- Ventral herniorrhaphy

GYN
- Bartholin cytectomy
- Cauterization of Cervix
- Cervical polypectomy
- Cold knife conization
- Colpotomy
- Condylomata acuminata excision or fulgeration
- Cryotherapy
- Dilatation and curettage
- Episiotomy repair
- Exam under anesthesia
- Fallopian tube excision
- Hymenotomy, hymenectomy
- IUD removal
- Laparoscopy, diagnostic
- Laparoscopy, bilateral tubal cauterization, ring or clip application
- Mini-laparotomy
- Shirodkar procedure
- Suture removal
- Therapeutic abortion
- Vaginal mass, excision or biopsy
- Vaginal septum removal
- Vulvar biopsy

Neurosurgical
- Carpal tunnel decompression
- Morton's neuroma excision
- Nerve repair
- Neuroma excision
- Temporal artery biopsy
- Ulnar nerve transfer

Table 2.2—*continued*

Orthopaedic
- Arthroplasty
- Arthroscopy, with or without operative procedure
- Arthogram
- Baker s cyst excision
- Bone resection
- Bone graft
- Bunionectomy
- Bursa excision
- Calcium deposit shoulder
- Carpal tunnel decompression
- Cast change
- Closed reduction fracture
- Conjoin tendon, release or removal
- Cortisone injection
- Dequervain's decompression
- Foreign body removal
- Ganglionectomy
- Hammertoe, correction
- Incision and drainage, abscess
- Manipulation of joints
- Morton s neuroma excision
- Myleogram
- Nail removal
- Nerve repair
- Olecranon bursa excision
- Open reduction fracture
- Pin insertion
- Phalangectomy
- Prothesis insertion
- Removal hardware
- Skin graft
- Soft tissue mass, excision
- Tendon repair
- Trigger thumb release

Plastic Surgery
- Amputation extra digit
- Basal cell cancer excision
- Blecnaroplasty
- Dermabrasion
- Face lift
- Fibrous capsule release
- Keloid resection
- Insertion expander
- Lipoma, excision
- Lipectomy
- Mammoplasty, augmentation
- Mass excision
- Nerve repair
- Otoplasty
- Reconstruction reduction fracture
- Release contractures
- Release pedicle flap
- Replace prosthesis
- Rhinoplasty
- Scar revision
- Skin lesion, excision
- Skin graft
- Septoplasty
- Suture removal
- Tendon repair
- Z-plasty

Urology
- Circumcision
- Cystoscopy
- Hyrocelectomy
- Needle biopsy
- Orchiopexy
- Penoplasty
- Urethral dilation
- Urethral warts, excision
- Vancolectomy
- Vasectomy
- Vasogram
- Vasovasotomy

Dental
- Bone insertion
- Full mouth restoration
- Genioplasty
- Teeth extraction
- Z-plasty

Medical
- Bronchoscopy
- Change biliary tube
- Colonoscopy
- ERCP
- Esophageal biopsy
- Gastroscopy
- Liver biopsy
- Renal puncture
- Venous samping

Blocks
- Differential spinal
- Intercostal
- Lumbar epidural
- Peripheral nerve block
- Stellate

* With the permission of Richard L. Myers, Administrator, Durham General Hospital, Durham, North Carolina.

patients who had been operated upon without hospital admission, also began to encourage this type of surgery. In February 1982 the Business Roundtable endorsed ambulatory surgery as a cost containment initiative.

As an acknowledged incentive to encourage the performance of more surgical procedures in the ambulatory setting, regulations implementing section 934 of Public Law 96–499, the omnibus Reconciliation Act of 1980, and its interpretation by the

Health Care Financing Administration, provided for 100% reimbursement under Medicare Part B for procedures done in that setting. Under this enactment and ruling ambulatory surgical centers were given the option of participating in the Part B program. Physicians accepting assignment for the listed procedures performed in ambulatory surgery centers will receive 100% of reasonable charges. Many major industries, including American Telephone and Telegraph Company; Motorola, Inc.; Shell Oil Company; Mobil Oil Corporation, and others have developed programs to educate their employees regarding the advantages of major ambulatory surgery. The companies make this type of care attractive to the employees by making it financially advantageous for them to participate (13).

An outstanding and highly successful example of what can be accomplished has been the work of Blue Cross-Blue Shield of North Carolina. This innovative company has conducted a major program throughout the state to inform physicians, hospital leaders and personnel, and the public of the many advantages of this form of care. In well-documented reports it is clearly evident that utilization has increased and significant savings effected (see Chapter 6, Part 3).

Though it is still too early to measure the full effect of the DRG (Diagnosis Related Groups) method of reimbursement for hospitalized Medicare patients, the fact that ambulatory surgical centers are exempt from these regulations indicates that the impact on greater utilization of ambulatory surgery can only be positive and very likely will be highly significant.

DR. HOFFMAN'S "RULE OF 40"

Dr. George L. Hoffman (14), in a 1982 *Bulletin of the American College of Surgeons*, suggests a quick way to recall most of the statistical information associated with ambulatory surgery.

"The rule is that about 40% of the operations done at the community level can be done on an outpatient basis. In addition, if you wanted to set up an outpatient facility, you would need to perform approximately 40 operations a month per operating room to make the facility cost-effective. Frequently an operation can be performed in an outpatient facility for 40% of what it would cost (on an outpatient basis) in a hospital.

He continues

"My friends involved in freestanding facilities have asked me to add a fourth corollary to my rule: about 40% of the cost can be saved by performing an operation in a freestanding facility instead of in a hospital-affiliated one, which has a higher overhead. This last point might be debatable."

Dr. Hoffman served on an American College of Surgeons Panel on Ambulatory Surgery and has worked for many years in this area, and his "40s" are subject to the reader's judgment.

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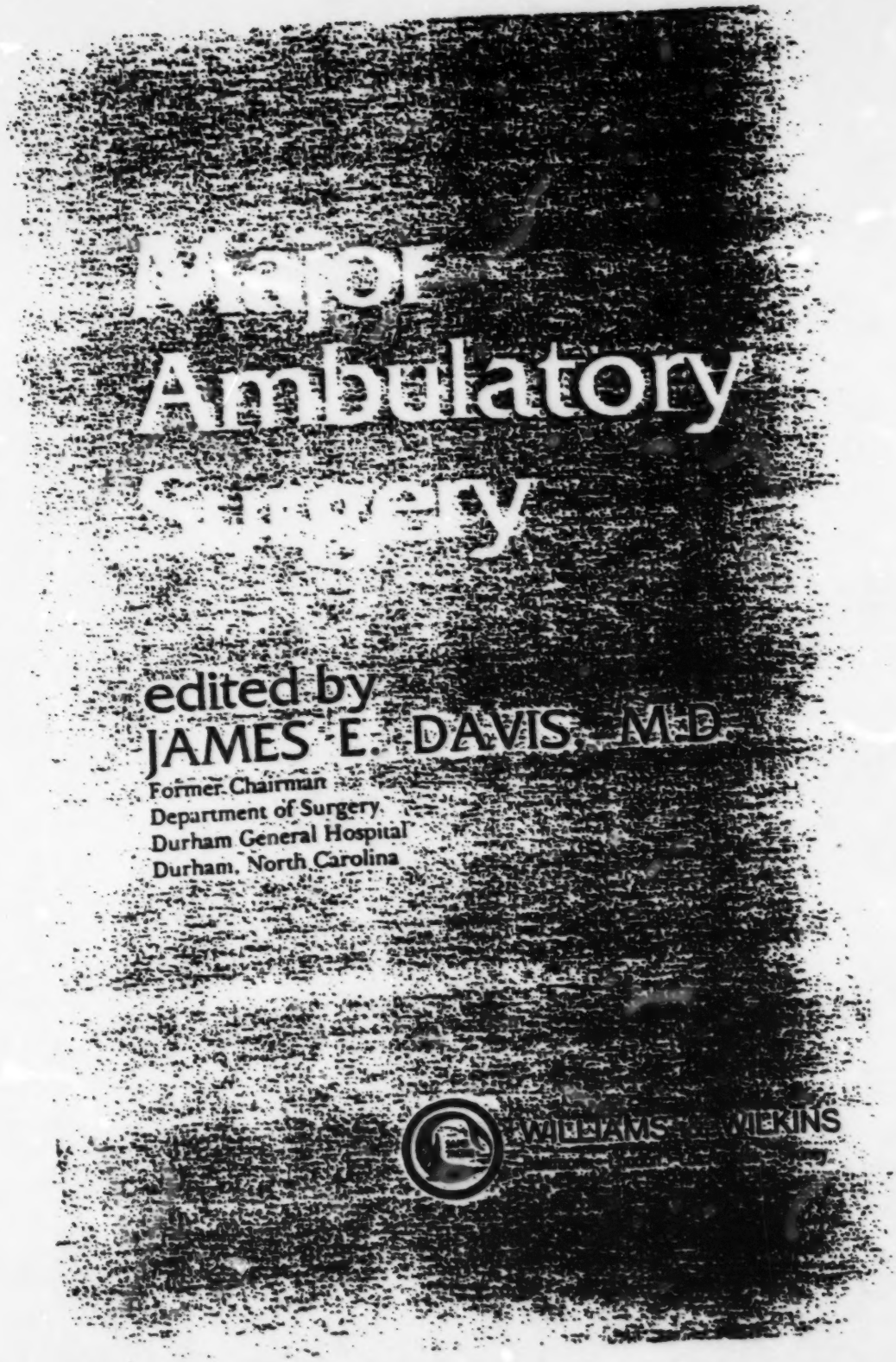
Ambulatory
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Accurate indications, adverse reactions, and dosage schedules for drugs are provided in this book, but it is possible that they may change. The reader is urged to review the package information data of the manufacturers of the medications mentioned.

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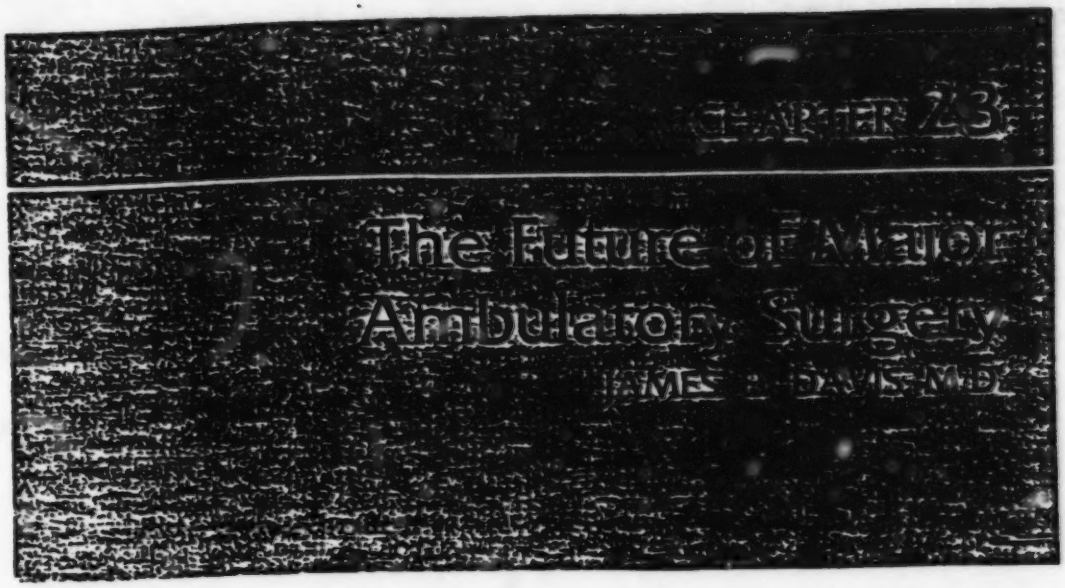

The expansion of major ambulatory surgery in this country in the future is inevitable. Specifically, it appears that the growth of this modality of providing surgical care will increase phenomenally in the years ahead. This growth will be represented by:

1. an increase in the total number of units delivering major ambulatory surgery care;
2. an increase in the total number of patients having operations in the ambulatory setting;
3. an increase in the total number of procedures performed on an ambulatory basis;
4. an increase in the number of types of procedures found suitable for use on ambulatory patients;
5. an increase in the percentage of surgical patients who receive their care in ambulatory surgical units.

Growth in the availability and utilization of major ambulatory surgery in the foreseeable future appears almost unlimited. There are two major inter-related reasons why this will occur.

MAJOR AMBULATORY SURGERY IS WELL ESTABLISHED

No longer is major ambulatory surgery a promising concept or even an evolving process. It is now totally accepted and respected as a superior method of providing surgical care. This has come about because:

1. Safety has been established. Members of all disciplines of the medical profession and of the public-at-large alike now have confidence in this method. There is no perception that a patient undergoing an operative procedure in the ambulatory setting assumes any degree of added risk in an effort to obtain greater convenience and economic savings.

2. It benefits all participants. *Patients* prefer ambulatory surgical care because it interferes least with their lifestyle. It allows an unwelcome but necessary interruption of their plans and can be accomplished in the briefest, least inconvenient and embarrassing manner. The cost savings are also understood by the patient.

Surgeons prefer ambulatory surgical care for their patients, when it is appropriate, because the care is simplified yet quite adequate. It allows the surgeons to spend a greater portion of their time in the care of sicker patients with greater surgical need.

Facilities providing the care, whether they be the hospital or another institution, find satisfaction in giving care at the appropriate level of need, without excess. They also find their referral base and their sphere of influence expand as they attract new patients.

Payors for the care benefit because charges are less than inpatient charges. If the pavor is a third party, it finds that the number of charges for "incidental" (and often unnecessary) studies and tests sometimes requested by inpatients is sharply reduced.

Communities in which this service is available benefit greatly (compared with communities in which it does not exist) in having a wider choice of services, greater convenience, and less costly care. The community-at-large develops greater confidence in its medical community and sees it as being innovative, current, and interested in the public welfare. New patients, referred from elsewhere for this specific service, benefit the entire community financially.

3. It is cost effective. Providing patients with needed and adequate care but avoiding excessive care obviously saves money. The patient with a low or intermediate level of surgical need is cared for properly and adequately in the unit prepared for such care. A similar patient, cared for by operating room and recovery room personnel who have been trained to handle any surgical problem and every surgical patient, often receives and is charged for more than he or she needs.

The major ambulatory surgical unit, whether it be a unit of the hospital or freestanding, which is financially organized to provide for its own expenses and to establish a reasonable reserve, best serves the major ambulatory surgical patient. Such patients should not be expected to pay a pro-rata share of the total hospital administrative cost because they derive no direct or indirect benefit from this administrative staff.

SPECIFIC CHANGES ARE OCCURRING THAT STIMULATE AND ENHANCE GREATER UTILIZATION

Public Demand

Public demand is increasing. The public is learning, more and more, about the benefits of having surgical procedures done on an ambulatory basis when appropriate, and understands better the societal and personal advantages. Surgeons are noting a distinct change in patient attitude as the subject of major ambulatory surgery is discussed with the patient. Formerly the surgeon had to suggest, explain, and recommend that the ambulatory route be chosen. Today, the patient suggests more often such a course or immediately demonstrates full understanding when the subject is discussed. However the need and value of continued and extended patient education, and education of the general public, persist.

Large segments of our population today fully understand the major societal problem of the high cost of medical care. Many readily identify major ambulatory surgery as an outstanding example of how these costs can be contained.

It can be anticipated that this public understanding and these public perceptions will increase in the future and will play a large and significant part in expanding the utilization of major ambulatory surgery.

Surgeon Appreciation

There is greater surgeon appreciation of the appropriateness of major ambulatory surgery. Just as the awareness and appreciation of the benefits of major ambulatory surgery have increased among the public, similar changes have occurred among surgeons. Though many surgeons have participated in providing major ambulatory surgery for years, others have been reticent to do so. Recently there has been a definite shift toward choosing this method of care by more and more surgeons and encouraging their patients to elect operative procedure in this manner.

Surgeons in increasing numbers are appreciating the progress made in developing safe, short-term anesthetic agents and anesthetic techniques for ambulatory patients. They know about more effective local anesthetic agents, including those available for control of postoperative pain. They realize that the public has increased

confidence in major ambulatory surgery. They fully understand the need to continue to combat the high cost of health care. They are well aware that patients almost invariably are more comfortable at home and more likely to return to normal physiological function of all organs when they are at home.

Just as surgeons are using the ambulatory approach to surgery more often, they are also extending their indications for major ambulatory surgery. A simple example, which is applicable to all surgical specialties, is the middle-age individual, in otherwise excellent health, with a small to moderate size inguinal hernia. Traditionally such individuals have not been operated upon in the ambulatory setting, usually because of the realization that the patient might have difficulty in voiding postoperatively. We now find this presents no problem because the rare patient who requires it can easily and safely be discharged from the major ambulatory surgical unit with a catheter in place. The patient is examined in the surgeon's office a few days hence and the catheter removed. This simple example represents only one of many ways in which surgeons find they can safely extend the benefits of major ambulatory surgery to more and more of their operative patients without sacrifice of quality of care. It is safe to predict that the current change in our concepts of which patients require hospitalization will continue and accelerate in the future. Many operative procedures, in all surgical specialties, not now regularly done in the ambulatory setting will soon be routinely performed in this manner.

Payor Encouragement

Insurance Incentives

Many insurance carriers now offer policies which mandate that certain operative procedures be done on an ambulatory basis. Other policies will allow full payment of the cost of the operative procedure only if it is done out of hospital, a significant reduction in payment occurring if the patient is hospitalized. Understandably, these policies are extremely attractive to employers when they purchase bulk insurance coverage for their employees. In the last decade we have seen a complete turnabout, especially with private insurance carriers, from a situation in which carriers had to be convinced to include ambulatory benefits in their "hospital package" to the situation today where they are strongly encouraging major ambulatory surgery.

Business and Industry

Employers, in addition to encouraging the use of major ambulatory surgery through their insurance coverage as above, are educating their personnel about the personal benefits, such as minimal change in lifestyle, which they can expect by having surgery done on an ambulatory basis. Consequently, large work forces are being taught that costs can be saved, lifestyles can be better preserved, but also that the employers will be pleased if the employees choose this route.

It has been well documented that when identical patients and identical operations are compared, one group having had major ambulatory surgery and the other having had inpatient surgery, the ambulatory patients return to work sooner. This factor has strong appeal to the employer and is also attractive to well-motivated employees, anxious to maintain good work and health records because they perceive such records as affecting their job security.

Mandate by Federal Government

The Federal government has now mandated that Medicare patients undergoing certain procedures must have these done in the ambulatory setting unless a physician has documented that the individual patient must be treated on an inpatient basis.

This has diverted a very large number of patients and procedures to ambulatory care. Whereas many surgeons, in a conscientious effort to help with cost containment, were progressively performing more procedures out of the hospital—and al-

though more and more patients were learning of the benefits of major ambulatory surgery and requesting it—the transition from the hospital to the ambulatory setting has been slow. This mandate has speeded up the transition tremendously and put the responsibility for not performing the procedure ambulatorily, and the responsibility for getting it excepted from the rule, clearly upon the surgeon.

The program of the Federal government to reimburse hospitals for Medicare patients according to diagnosis related groups (DRGs) does not apply to ambulatory patients. This will, indirectly, lead to more major ambulatory surgery. Patients, surgeons, and hospital administrators, all concerned about reimbursement under DRGs will indirectly, possible even subconsciously, find ambulatory care more attractive, when there is an appropriate option.

Payor Regulations

Some screening mechanisms, established by insurance payors, such as "prior to admission" approval change some planned inpatient procedures to the major ambulatory surgical unit. An example is the surgeon who plans to admit a patient for breast biopsy, but when authorization for admission is requested of the carrier, the carrier insists that ambulatory care would be more appropriate. Often the surgeon is convinced and the procedure is in fact shifted from a planned inpatient stay to an ambulatory setting.

As physicians and surgeons are subjected to increasing amounts of regulation in the years ahead such regulations will doubtless increase the number of patients who are ultimately cared for on an ambulatory basis.

Changes in Medical Practice Patterns

1. Increased Number of Physicians

As the large number of physicians already in undergraduate or graduate medical education programs mature to the practice phase of their careers, the "excess number of physicians" will increase. This larger number results in more competition among practitioners, including surgeons, who will be required to be innovative in the marketing and the provision of their services. Consequently surgeons will have a greater incentive to offer that which is attractive to patients and that which appears to be innovative, rather than following more traditional patterns of care which would include more inpatient admissions. Consequently, the patients will receive more information about ambulatory surgery, will be more strongly encouraged by the surgeon to accept it when appropriate, and it is reasonable to expect that a greater number of people actually will undergo their operative procedures out of the hospital.

2. Alternative Payment Mechanisms

As Independent Practice Associations, Health Maintenance Organizations, Preferred Provider Organizations, and other forms of prospective payment to surgeons increase in numbers and in size more ambulatory care, including more major ambulatory surgery, will be provided. Under these mechanisms, the surgeon is placed at some degree of "financial risk" and consequently he has an incentive not only to provide quality care but to see that it is done as inexpensively as is feasible. Unlike the traditional "fee for service" method of payment in which the surgeon is peripheral to the financing of the care he provides, under these new alternative methods he directly participates in the financial features of this care. Consequently, one can expect that the surgeon in order to avoid costly hospitalization, will attempt to find ways to provide this care on an ambulatory basis as long as the quality is preserved.

3. Technological Advances

New methods of providing surgical care, in many instances, will serve to move operative procedures from an inpatient status

to the ambulatory surgical unit. Laser surgery is an example.

Both surgeons and major ambulatory surgery unit directors see this as very appropriate ambulatory care and procedures involving laser therapy increasingly will be shifted to the ambulatory site. Ophthalmic laser procedures are well established and these can be used as the driving force to broaden the availability of laser therapy in other surgical specialties. Laser enthusiasts have estimated that about 30% of all operative procedures will be done with the use of lasers in the near future.

4. Expanding Presence of Medical Corporations

Both corporations which own and those which provide medical management of health care facilities are well entrenched in the medical ambulatory field. Their interest and their participation in ambulatory care is rapidly expanding. Thus they constantly stimulate action and cause to be made available more medical ambulatory units. This is done both by their own activities and by those of their competitors, such as hospitals, physician groups, and other commercial interests in the field of ambulatory care. There are many communities in which the final impetus either to establish a major ambulatory surgical unit or to upgrade an existing unit has come about because of the threat of corporate interests coming into the community if something definitive is not done. Yet medical corporations continue to increase their own share of the major ambulatory surgical market.

5. Recent Identified Sources of Patients

Domociled Patients. Currently we are identifying patients domociled in basic health care facilities which are able to assure necessary postoperative supervision for major ambulatory surgery, thus making these patients candidates for this type of surgery. Patients in nursing homes, extended care facilities, educational institutions, and even many penal institutions have readily available services supplied by a registered nurse, licensed practical nurse, physician's assistant, or other trained individuals who can provide the necessary postoperative supervision. These factors assure the surgeon that his patient, upon discharge from the major ambulatory surgical unit, will be cared for properly. Heretofore such patients have been transferred as inpatients from their institutions of residence to hospitals, even for a low or intermediate level of surgical care. A large number of these patients now can be treated through a major ambulatory surgical unit and, after discharge, receive their supervisory care in their parent facilities, before returning to the surgeon's office for after-care.

Similarly, many aged patients and patients with marginal support at home can also receive care in the major ambulatory surgical unit if prior arrangements have been made for the social service agencies to provide visiting nurse service, homemaker service, and other types of supportive services to these individuals after they return to their own residences. Again, many of these individuals heretofore have required hospitalization simply because it was believed that adequate post-discharge supervision could not be provided.

Military Personnel. It has been reported rather extensively that the medical corps of the military services tend to underutilize ambulatory surgery on the basis that proper postoperative supervision will not be available. However, this attitude is gradually changing as military physicians and surgeons realize that with dispensaries, well-trained medical corpsmen, available nursing service and other support personnel, many patients do not need to be hospitalized to have the correct level of "intermediate surgery."

Home Health Care. As the nation turns its attention to various ways to avoid or shorten periods of hospitalization, home health care has assumed greater importance. As our abilities to provide this home health care for patients who are discharged

from the hospital sooner than has been traditional increase, and as our interest and accomplishments in the hospice movement and other home health services develop, it is obvious that these methods and this group of people can also provide the necessary postoperative supervision which has been needed but was not available to a large number of patients.

Although home health care was developed for other types of patients, to couple home care and major ambulatory surgical care together is quite natural and works effectively. This alliance of different types of care allows a large segment of the patient population, previously ineligible for major ambulatory surgery, now to enjoy the benefits of this modality of care and to avoid hospitalization for many operative procedures.

SUMMARY

In summary, the future of major ambulatory surgery appears bright. It appears that the numbers of facilities, operations, surgeons, other physicians, patients, and communities who will be participating in major ambulatory surgery will increase significantly. In time, however, the optimum number of each of these will be reached and surpassed. Consequently it behooves all who participate in providing this modality of care to keep in mind, as competition constantly increases, that marketing of services will be second in importance only to the provision of quality care. In order to continue to provide service of outstanding quality, and to compete in an ever-busier climate, one must remember that keeping the patient's welfare in mind at all times is absolutely essential. In the final analysis, the deciding factor between those who succeed and those who do not—or even between those who succeed more than others succeed—may very well be the satisfaction and responsiveness of the patient group that is served. Medicine and surgery have no greater mandate than always to keep the patient's interest uppermost and far ahead of all other considerations. Those individuals who can do this in the face of competition, regulation, cost-containment demands and other social-economic-political pressures, will be the ones who achieve major success.

Pictured is the Durham (N.C.) Ambulatory Surgical Center (Fig. 23.1) which opened in October, 1985. A floor plan of this extremely functional and effective unit is shown (Fig. 23.2).

Figure 23.1. *The Durham (N.C.) Ambulatory Surgical Center.* This unit, which opened in October, 1985, represents the state-of-the-art in contemporary units.